

I. Current Substance Use

A. Alcohol Screening Questions

1 Drink = 12 Ounces of Beer

1. How often do you have a drink containing alcohol? If "Never", proceed to Drug Screening Questions.	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly or less	<input type="checkbox"/> 2-4 times a month	<input type="checkbox"/> 3 times a week	<input type="checkbox"/> 4+ times a week
1a. How many drinks containing alcohol do you have on a typical day when you are drinking?	<input type="checkbox"/> 1 or 2	<input type="checkbox"/> 3 or 4	<input type="checkbox"/> 5 or 6	<input type="checkbox"/> 7 to 9	<input type="checkbox"/> 10+
1b. How often do you have six or more drinks on one occasion?	<input type="checkbox"/> Never	<input type="checkbox"/> Less than monthly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily or almost daily

Alcohol Screening Score: _____ Was a Brief Intervention Provided? ☐ Yes ☐ No

B. Drug Screening Questions

1. Have you used any drug in the past 30 days that was NOT prescribed by a doctor? ☐ Yes ☐ No

2. Drug Type(s) Used (Indicate with an "*" which substances are most preferred.)	Ever Used?		Recently Used? (Past 6 Months)		Route of Administration or other comments (IV use, smoking, snorting, etc.)
	Yes	No	Yes	No	
Amphetamines (Meth, crank, ice, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cocaine or crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nicotine (Cigarettes, cigars, smokeless tobacco)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Opiates (Heroin, codeine, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Over the Counter Meds (Cough syrup, diet aids, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sedatives (Pain meds, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

C. Additional Comments (i.e. frequency, duration of use, etc.):

II. Family History of Alcohol and/or Drug Use

Please describe any history of family alcohol and/or drug use (i.e. mother, father, etc.)

III. Past and Current Substance Use Treatment/Self-Help

1. Have you received help in the past for substance use issues (e.g. Self-Help or Professional)? ☐ Yes ☐ No
If yes, please list the dates you were enrolled: From _____ To _____ From _____ To _____
Was it beneficial? If so, how?

2. Are you currently enrolled in a substance use program? ☐ Yes ☐ No
If yes, what was your date of enrollment? _____
Please specify the type of program it is:

Were you referred to mental health services by this program? ☐ Yes ☐ No
Referred by: _____ Contact Number: _____
☐ Records were requested on (date): _____

3. Additional comments:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

ID#:

Agency:

Provider #:

Los Angeles County – Department of Mental Health

IV. Benefits of Substance Use

How true is the following about substance use for you:	Very True	Somewhat True	Not True	Comments
It is important in socializing with friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
It helps me meet and get to know people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
It lowers my anxiety when I'm with people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
It makes me feel less depressed or empty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
It makes me feel less anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
It helps me forget my problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
It helps me sleep better	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
It gives me something to look forward to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
It is an important source of pleasure to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
It helps reduce my boredom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
It is one of the only things that makes me feel okay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
It is chiefly a habit or helps to avoid withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
It enhances sexual experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
It helps me lose weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

V. Costs of Substance Use

Is it possible that your substance use has played a role in or contributed to any of the following:	Yes	No
Problems keeping or getting housing (i.e. eviction, homeless)?	<input type="checkbox"/>	<input type="checkbox"/>
Problems at school or work?	<input type="checkbox"/>	<input type="checkbox"/>
Legal problems (i.e. DUI, possession, public intoxication, dealing)?	<input type="checkbox"/>	<input type="checkbox"/>
Money problems (i.e. lack of money)?	<input type="checkbox"/>	<input type="checkbox"/>
Developing or not attending to health problems (i.e. physical exams, dental exams, treatment)?	<input type="checkbox"/>	<input type="checkbox"/>
Feeling sick before or after using?	<input type="checkbox"/>	<input type="checkbox"/>
Ignoring my mental health treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Increasing my mental health symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Not taking my medications as prescribed?	<input type="checkbox"/>	<input type="checkbox"/>
Being rejected or judged by others?	<input type="checkbox"/>	<input type="checkbox"/>
Conflicts with or losing friends and/or family?	<input type="checkbox"/>	<input type="checkbox"/>
Getting into dangerous situations (i.e. that involve weapons, unprotected sex, trading sex for drugs, sharing needles)?	<input type="checkbox"/>	<input type="checkbox"/>
Feeling a sense of anger/guilt/shame or feeling like a failure?	<input type="checkbox"/>	<input type="checkbox"/>

VI. Readiness for Change/Treatment Plan Identification

1. In looking over the benefits and costs of your alcohol/drug use, how do the costs compare to the benefits?
2. Which benefits seem most important to you?
3. If we could identify or develop healthier ways for you to achieve those benefits (identified in #2), do you think it might be easier for you to cut down on your alcohol/drug use? ☐ Yes ☐ No
4. Which of the costs do you think cause the most overall problems for you?
5. Are you willing or wanting to address any of these costs? If so, how?
6. Which of these costs do you think affects your Mental Health symptoms the most and might be important to try to reduce?
7. On a scale of 0-5, how ready are you to start working on finding new ways of achieving the benefits? _____
On a scale of 0-5, how ready are you to start working on reducing the costs? _____

Assessor's Signature & Discipline

Date

Co-Signature & Discipline (if required)

Date

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

ID#:

Agency:

Provider #:

Los Angeles County – Department of Mental Health